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Review Article*

FIRST DO NO HARM: LAW, ETHICS AND HEALTHCARE. Sheila A.M. McLean, ed., Aldershot: Ashgate, 2006. ISBN: 0 7546 2614 8 £65.00

I. Introduction

In issue 7(2) of this Journal, Sheila McLean wrote a heartfelt acknowledge of the career achievements of John Kenyon Mason, widely known as Ken.¹ McLean had just completed the editing of this book, which opens with the statement that “[a] glance at the list of contributors to this festschrift to celebrate Ken Mason’s contribution to Medical Law should be sufficient to show the reader just how much Mason is loved, respected and admired” (xiii). This is no mere hyperbole. The 37 chapters and two prefaces are written by a striking collection of no fewer than 44 contributors, the list of whom reads like the Who’s Who of medical law. The result is a book that is not easily reviewed. Rather than impose my own thematic structure,² this review article will seek to convey the essence of the book as it stands by addressing the chapters sequentially, though providing no more than a brief summary of some. The Hippocratic injunction of the title provides a unifying theme only because it is capable of carrying divergent interpretations. I hope to show that this plurality of themes and perspectives is—excuse the pun—just what the doctor ordered for medical law, as it cannot fail to excite the thoughtful mind and invite further inquiry.

II. The chapters

Chapters 1–5

The first chapter, written by Jonathan Montgomery,³ seeks to examine the question of whether medical law can be *legitimate* when it seeks to “dictate or proscribe a particular course of action in the face of [moral] controversy” (2). Montgomery rejects many familiar responses to the legitimacy problem as unconvincing or insufficient, including those seeking to distinguish public from private morality, those seeking to apply a human rights-based approach (which he analyses by reference to the rights recognised by the European Convention of Human Rights), and those relying on the procedural legitimacy provided by parliamentary democracy. He summarises the issues by mapping out three tracks, with his own being advanced as the middle path and the two side-tracks purportedly shown to be dead-ends. What I shall call the “particular moral position” track is dismissed on the basis that it denies the legitimacy problem, moves from moral debate to legal rules without concern for moral pluralism, reduces medical law to the technical application of bioethics, and is vulnerable to challenge by those who adopt a different morality “as it could give no account of why their moralism should be resisted” (13–14). The diametrically opposed position, which I shall call the “patient choice” track, views the legitimacy problem as insuperable and allows medical law to reduce to no more than “a combination of consumer law (in relation to private relationships) and public law (in relation to state spending)” (14). Montgomery’s middle path considers the legitimacy problem to entail a significant degree of moral indeterminacy but nonetheless sees a role for medical law in providing structure for moral decision-making.

Montgomery presents a variant of the Millian harm principle in which the proscribed

harm to others is interference with the ability of individuals to make their own ethical decisions. Thus, the role of law is to “protect both patients’ and professionals’ rights to exercise their judgment and prevent outsiders from dictating to them what should happen” (15). The result is a compromise that will only persuade those who accept it from the outset. Fortunately for Montgomery, many do. The rejection of the particular moral position approach, of which I am an adherent,⁴ turns on a number of popular assumptions and elisions, in particular, the equation of moral disagreement with rational indeterminacy. The central problem is that Montgomery’s purportedly mid-way position is not free of the challenges faced by the “particular moral position”. We are being invited to wear the emperor’s cloak of neutrality to protect us from the wind of pluralism. As Brownsword argues later in this book, the harm principle is far from morally neutral; its content and application cannot escape choices between irreconcilable moral views.

The next three chapters address related but ultimately very different topics. Robin Downie seeks to defend casuistry against some objections and suggest that it has important contributions to make to medicine.⁵ Kenneth Boyd examines the interaction between Hippocratic ideals in medicine and democratic ideals in society.⁶ Ian Freckelton explores recent developments in the regulation of health care practitioners in Australia, Canada, New Zealand, and the UK.⁷

In the fifth chapter, Lawrence Gostin explores the impact of the WHO’s International Health Regulations (IHR).⁸ These were first adopted in 1951, as the International Sanitary Regulations, and fundamentally revised in 2005. According to Gostin, the 2005 revision was a laudable response to an otherwise disastrous confluence of frightening outbreaks and pandemics that provided the political motivation to challenge outdated assumptions about sovereignty, horizontal governance, and entrenched power. Gostin persuasively argues that the result is a positive step towards a coherent international law regime for global health. As Gostin concedes, however, international law is ultimately only a small part of effective monitoring and management of international health threats.

Chapter 6–10

Chapter six is the first of the book’s chapters to focus on the regulation of human research and experimentation, a topic brought to the forefront of medical law by Mason and McCall Smith’s pioneering work *Law and Medical Ethics*.⁹ In this chapter Don Chalmers tracks the transition of medical research ethics from the Nuremberg Code and the later Declaration of Helsinki to current formal regulatory structures, focusing on the Australian experience.¹⁰

The regulation of research and experimentation is not, however, the focus of chapter seven. Instead, Gerard Magill analyses the limits of malpractice litigation in the context of medical error and patient safety.¹¹ Magill notes that there is a growing awareness of the problem of medical error in US healthcare as a result of a number of official reports and sensationalist media coverage to the effect that deaths from medical errors “were the equivalent of a 747 jet going down every day killing all its passengers” and “hospital beds should post a warning that medical care can seriously damage your health” (101–102). He argues that experience in road safety, aviation, and occupational health shows that a reduction of errors is more likely to brought

about by adopting procedures designed to reveal and address causes, than by procedures designed to attribute blame and punish individuals for their errors. Thus, he opines, the US should seek to move away from a “professional sanctions model”, as epitomised by existing malpractice litigation practises, to a “proactive and preventive patient safety model” (111). These issues are all too familiar to non-US medical lawyers watching similar moves towards patient safety models closer to home, albeit from arguably less litigation obsessed starting points. In the UK, the patient safety movement underlines significant reshaping of the professional regulation of doctors, including the introduction of the new revalidation procedure for doctors.¹² It is therefore a little surprising that this chapter, in a book dedicated to one of the UK’s leading medical lawyers, should fail to make even a passing reference to developments outside of the US.

Chapter eight—written by Veronica English, Rebecca Mussell, Julian Sheather, and Ann Sommerville—seeks to examine the limits of patient autonomy and the ability to demand and refuse treatment, focusing on genetic testing and knowledge, medical research on patient data, cadaveric organ donation, and mental health law.¹³ They contend that autonomy (defined as “the capacity to make reasoned decisions and act on them”: 117) is often overvalued relative to other moral values. The other moral values identified by the authors have a distinctly communitarian flavour: “altruism and concern for others” (118); “the common good” (119); “emphasis on responsibilities of individuals as well as rights” (121); and “all patients’ responsibilities for promoting the general good” (130). This chapter therefore more than nods in support of Mason’s own self-declared communitarian persuasion. It is, however, a pity that neither the epistemic basis of their version of communitarianism (beyond the merest mention of social contract theory: 119) nor its details receive considered analysis.

Perhaps not surprisingly, Graeme Laurie’s chapter nine is one of the most explicitly influenced by Mason’s work.¹⁴ He takes as his starting point an unpublished paper in which Mason sought to choose the five most significant UK medical law cases of the past 30 years. Mason’s communitarian views on the limits of patient autonomy led him to choose *Re B*, *Gillick v Norfolk and Wisbach Area Health Authority*, *Re MB*, *A-G’s reference (No. 3 of 1994)* and *R v Cox*.¹⁵ Laurie explicates and defends Mason’s view that *Re B* is a seminal case on the treatment of those who lack autonomy and that *Gillick* is defensibly interpreted as recognising the legal authority of mature minors to consent to treatment but not to refuse treatment that would prevent ongoing suffering or death. Consideration is then given to *Re MB* and *A-G’s reference*, on which Laurie considers the objections raised by Mason and presents his own view that issues concerning the status of the fetus in a maternal/foetal context “may be an area where maintaining clear-line thinking—even if the thinking itself is far from clear—is the only acceptable judicial policy” (145). The discussion of *R v Cox* indicates that Laurie and Mason disagree on the potency of the empirical slippery slope argument against active euthanasia informed by experiences of the Netherlands—Mason is persuaded by this argument, Laurie is not. This thought-provoking chapter is one of the best in the book. It highlights the degree to which moral controversies underlie medical law and, in my view, provides further examples of situations where the adoption of different ethical premises will lead to very different conclusions.¹⁶

In chapter 10, Deryck Beyleveld analyses the concept of privacy in relation to

research on patient data.¹⁷ It is not appropriate for me to comment on this chapter as it forms the starting point for a piece that I have co-written with its author.¹⁸

Chapters 11–15

The re-occurring theme of medical research is also the focus of chapter 11, in which Pamela Ferguson presents an interesting analysis of an empirical study into why patients participate in clinical trials.¹⁹ This is followed by Margot Brazier’s engaging chapter on the many topics on which she and Mason have disagreed, on some of which she indicates that she is no longer sure that the disagreement remains.²⁰ These topics are stylishly bound together by an evocative hypothetical scenario in which we are asked to consider Sam, a boy whose cells are found to have a dramatic capacity for regeneration and are therefore considered by scientists to hold the potential “to understand and cure most human diseases unrelated to the aging process” (189). By manipulating this scenario—so that Sam is considered as a living three-year-old, a road kill victim, and an embryo—Brazier is able to evoke an array of ethical and legal questions on the use of embryos and tissue as medicines and research materials. She argues that the potential for use of humans as medicines is bedevilled by what she refers to as the “tyranny of language”—the rhetorical import of the descriptions that we give to our bodies, parts, or their uses (201). Brazier reveals that the potential of humans as medicines has led her to reconsider her opposition to embryo research and invites the reader to consider whether our duty to rescue others entails a duty to make “available parts of ourselves to save others” (202). This chapter therefore provides powerful examples of the practical significance of different moral stances on the extent and limits of our positive duties.

Alastair Campbell, in chapter 13, addresses biobanks (large-scale genetic databases).²¹ Campbell identifies four key ethical issues: the question of consent, self-interest and altruism, the potential harm to participants, and the issue of the custodianship and use of biobank resources. The first of these is, perhaps, the most vexing and is laudably summarised by Campbell:

The whole rationale of the biobank enterprise means that those enrolling cannot be told precisely what uses will be made of the resource in the future. Since the data gathering will last several years and the resource itself will continue to grow and to be available for use for at least two or three decades, the aims of the project must necessarily be described in very broad terms. It is clearly impossible to know at the outset the range of possible research uses. Thus, the consent being gained is quite different from the standard consent to participation in health research, when a full description has to be given of a specific research proposal, with a justification for the use of tissue or data, as well as a statement of the likely outcomes of the research. (204)

Many differing responses have been offered. Some theorists suggest a terminological move whereby the language of “consent” or “informed consent” is replaced with terms such as “blanket consent” (to highlight the breadth of the future research)²² or “blind consent” (to highlight the lack of information on the details of the future research).²³ Campbell himself notes that some argue that the consent can be fully informed and valid if participants are aware of the broad purposes of the future research and all the safeguards on the control and use of the data, whereas others regard the initial consent as no more than provisional. Campbell urges readers to recognise that every attempt to re-contact participants brings significant additional

costs while also granting control to participants. Most significantly, he argues, the real motivation for participation often stems, not from an informed understanding, but from the participant's trust in clinic staff and their sense that it is a worthwhile project. Thus, he opines, we should move from focussing on the information divulged to participants to "the context for obtaining consent and the motivations of those who enrol in the project" (207). The rest of his chapter examines these issues, focussing on the need for structural safeguards to protect altruism and trust.

In chapter 14, Jean McHale examines the reforms to the regulation of medical research on those who lack capacity introduced by the Clinical Trials Regulations,²⁴ the Mental Capacity Act 2005, and the Human Tissue Act 2004.²⁵ She argues that there is "a real risk" that in ten years time these reforms "will be viewed as a recipe for fundamental uncertainty" (233). I agree. I have argued elsewhere that the regulation of emergency research is now incoherent and potentially open to legal challenge, and this issue has been exacerbated by amendments made to the Clinical Trials Regulations in 2006.²⁶

In Chapter 15, John Devereux explores the case law on competency, understood as "the ability to understand the nature of the treatment", and examines what is meant by the nature of the treatment.²⁷ The discussion utilises an impressively wide range of English and commonwealth case law, albeit taking as its discursive starting point a case that was actually overruled in May 2004.²⁸ In the last section before the conclusion, Devereux examines the question of whether "in order to be competent, a patient needs to demonstrate actual understanding of the treatment information or merely an ability to understand treatment information" (252). He opines that this is a distinction between understanding the information with which one is presented and having the ability to understand information of a similar level of complexity. By way of example, he argues, a patient who is able to solve quadratic equations could be viewed as having the ability to understand information of the same level of complexity relating to her medical condition but, nonetheless, as lacking actual understanding of that medical condition where she is so shocked by the diagnosis that "she refuses to deal with the situation" (252). With respect, a patient who is *unable* (as opposed to unwilling) to exercise her cognitive abilities in the specific circumstances in which she finds herself does not, at that time, possess the ability to understand her medical condition. Conceptually at least, there is a difference between being cognitive able to make a decision with respect to the given situation (having both the dispositional cognitive ability to understand and being occurrently able to exercise that ability) *and* applying those abilities to attain actual understanding.²⁹ The apparent difficulty is that, in practice, evidence of actual understanding is the best evidence of possession of these abilities. Nonetheless, it is possible to conceive of hypothetical situations—in addition to those in which the patient has been deprived of the requisite information—where a patient could be meaningfully viewed as possessing the relevant abilities whilst not actually understanding. Imagine, for example, a patient who is fully willing and able to discuss the nature of his terminal disease but *chooses* not to listen to or discuss the nature of a less complex, non-terminal disease that he also possesses. Properly considered, English law does not invariably equate non-understanding with a lack of competence. The Mental Capacity Act 2005 says that a person will only lack capacity if he is "*unable* to make a decision for himself in relation to the matter *because of* an impairment of, or a disturbance of the functioning of, the mind or brain" (s.2(1), my emphasis). This has also been declared to be the

common law position.³⁰ A person who has no impairment preventing him from making a decision, but does not actually understand the relevant information, will not lack capacity. As Munby J put it in the much maligned *Burke* decision,

Essentially capacity is dependent upon having the ability, *whether or not one chooses to use it*, to function rationally: having the ability to understand, retain, believe and evaluate (*i.e.*, process) and weigh the information which is relevant to the subject-matter.³¹

Chapters 16–20

In the sixteenth chapter David Meyers analyses a much ignored aspect of the decision in *Chester v Afshar*.³² He is not concerned with the issue of the causal link between the breach of duty and the injury, but with the nature of the legal duty to inform the patient of a 1–2 per cent risk of serious neurological damage inherent in the spinal surgery. He starts with the Court of Appeal’s decision in *Pearce v United Bristol Healthcare*.³³ According to Meyers, *Pearce* was a “remarkably bold” decision, as it effectively adopted the minority judgment in *Sidaway v Board of Governors of the Bethlem Royal Hospital*³⁴ via ambiguities in the speeches of the majority, so that a doctor is (in effect) required to disclose the information that a reasonable patient would want to know (259). This viewpoint has both supporters (of whom I am one) and opponents.³⁵ Meyers notes that dicta in *Chester* clearly support *Pearce*.³⁶ He points out that the House of Lords could have easily reconciled *Sidaway* and *Chester* on the basis that Mrs Chester had specifically asked about the risk and there is powerful dicta in *Sidaway* to the effect that a doctor must answer the patient’s questions “truthfully” and “fully”.³⁷ Meyers contends, however, the House of Lords “did not choose to do that” (263). Instead, he argues, the House of Lords viewed the risk as one that the doctor had a duty to disclose on the basis that a reasonable doctor would regard it as a significant risk that would affect the judgment of a reasonable patient, irrespective of whether or not Mrs Chester had asked about it.

There are a number of limits to the authority of *Chester* on the breach of duty issue. First, their Lordships’ discussion on this issue is technically *obiter*, as both parties accepted the existence of a duty to disclose the specific risk in question to Mrs Chester.³⁸ Secondly, their Lordships did not purport to overrule *Sidaway*, which, as Meyer recognises, involved the non-disclosure of a risk that was “almost identical” (256). Approval of the interpretative gloss placed upon *Sidaway* by *Pearce* is not the same thing as holding that the *Sidaway* would now be decided differently on its facts. Thirdly, the fact that Mrs Chester had asked a specific question about the risks—which was recognised as imposing a duty to disclose in both *Sidaway* and *Pearce*³⁹—was arguably a background factor.⁴⁰ Nonetheless, Meyer presents a persuasive argument that “it may be that *Chester* will prove to be more noteworthy for defining the scope of the doctor’s duty to warn his or her patient of the risks inherent or special in the treatment being proposed” (270).

Also addressing the disclosure of information, Emily Jackson argues that the idea that tort law protects patients’ interests in access to information about their medical treatment is a “pretence” (286).⁴¹ Battery has a very narrow ambit, restricting it to exceptional cases, and patients bringing negligence actions are severely hindered by the need to show breach of the relevant standard of care and causation. Jackson maintains that the present position mistakenly equates the patients’ need information

with the need to protect themselves from physical injury caused medical accidents. Jackson's claim is, in essence, that the existing law provides little redress for autonomy-focused dignitarian harm.⁴²

In chapter 18, John Harris explores some problems applying consent-based reasoning to the dead, the unborn, and the incompetent.⁴³ Harris forcefully argues that consent can be neither a necessary nor sufficient justification for all our actions; and other justificatory strategies require careful analysis. For example, according to Harris, consent cannot be a necessary justificatory requirement for doing something to or for children (for children who are not dressed, fed, etc. would not survive) nor can the best interests of the child (for this is incompatible with many routine decisions that parents make for their children, such as letting them cross busy roads, eat at McDonald's, and receive MMR vaccines). It is difficult to dissent from the view that consent is routinely overplayed as a justificatory tool and Harris' arguments by analogy are, as usual, worthy of serious consideration.

Chapter 19 presents an analysis of the law on negligently caused psychiatric harm, written by Harvey Teff.⁴⁴ He argues that the significance of "sudden shock" and "horrifying event" in recent cases has diminished "but it still has undue capacity to determine legal outcomes" (316). The result, Teff persuasively concludes, is a mismatch of law and medicine, whereby the law appeals to outdated ideas disconnected from contemporary clinical understanding of psychiatric harm.

Elaine Sutherland, in the twentieth chapter, considers whether there is a legally recognised right not to procreate.⁴⁵ She points out that since many individuals cannot realistically avoid procreation by celibacy or engaging only in same sex relationships, legal systems have had to face the choice not to procreate in a variety of circumstances. Legal systems, Sutherland claims, are generally willing to respect the choice not to procreate when asked to referee the interests of two private individuals (such as where one spouse seeks divorce because of the other's intentional non-procreation), but are less so where an innocent third party is involved (such as where one parent sues the other for the conception of a child following the defendant's deception on the lack of the need for additional contraceptive precautions). Sutherland thereby elicits an underlying principle that goes a long way towards explaining apparently divergent responses towards the right not to procreate.

Chapters 20–25

Bernard Dickens, in chapter 21, presents a detailed, thought-provoking critique of legal responses to conscientious objection.⁴⁶ Doctors' recourse to conscientious objection most commonly takes the form of refusals to participate in procedures concerned with abortion and other matters of reproductive health on the grounds of religious conviction. Unfortunately, overly broad conscientious objection clauses can, Dickens argues, easily lead to protections that serve as a *shield* for religious conviction becoming a *sword* by which compliance with religious beliefs is imposed upon those who do not share them. This is likely to disproportionately affect particular groups, such as women and those unable to seek alternative access to the treatment in question. As Dickens recognises, little comfort is likely to derive from the realisation that, occasionally, conscientious objection clauses can unintentionally protect those with convictions diametrically opposed to the group they are intended to

protect. The extremely broad clause in the Mississippi Health Care Rights of Conscience Act (341–343) might unintentionally protect abortion providers opposed to complying with laws requiring the distribution of anti-abortion pamphlets but it could also protect doctors who refuse to terminate a life-endangering pregnancy. This chapter, therefore, highlights the danger of broad conscience clauses that are capable of denying access to healthcare that could not, legally or ethically, be denied by more direct means.

Kerry Petersen devotes chapter 22 to a topic touched on by Sutherland and Dickens—the regulation of abortion.⁴⁷ She argues that in Australia abortion is predominately treated as a health matter, which has contained the controversy and serves the health interests of women, but reduces the scope for debate on the underlying issues and on social policies to reduce the incidence of abortion (esp. 355 and 368). Sheldon has previously made many of these points in relation to the regulation of abortion in Britain.⁴⁸ Sheldon has, in particular, argued that the “medicalisation” of abortion has paved “the way for women’s access to the provision of safe, legal terminations”, “played a central role in the apparent depoliticisation of abortion”, and that this reduces the scope for those of a pro-choice persuasion to ensure the realisation of their values in practice.⁴⁹ While Petersen does not mention Sheldon’s work, Petersen suggests that she is no more willing to accept the pro-choice position than she is the pro-life position, arguing that both are polarised extremes.

In chapter 23, Penelope Beem and Derek Morgan consider the regulation of, and access to, IVF services in Australia, Canada, New Zealand, Ireland, and the UK.⁵⁰ The linking idea, encapsulated by the words of the Tina Turner song alluded to by the title, is that love has little to do with it, though other values and emotions (“second hand emotions”) can be identified. The chapter thereby presents an interesting update on the development of regulatory approaches to IVF and its related cousins, and the general direction of regulatory responses.

Following on from Beem and Morgan’s analysis of the regulation of IVF, Michael Freeman examines a specific issue brought about by use of developments in assisted reproductive technology: the use of preimplantation genetic diagnosis (PDG) and tissue typing (HLA) to enable the selection of an embryo that is intended to become a donor for an existing, sick child.⁵¹ Freeman explores the regulatory and ethical aspects of creating so-called “saviour siblings”, arguing that the Court of Appeal and House of Lords in the Hashmi case reached the right decision.⁵² He expresses concern, however, that the House of Lords did not consider the procedures that may lawfully be applied to the subsequent child beyond the trite statement that any operation upon the child must be in the child’s best interests. Freeman also claims that the HFEA would permit parents to use PGD and tissue typing to treat their own illness (404), though no source is cited.⁵³ In any event, many regulatory developments have taken place since this chapter was published. In particular, the Government has issued both a White Paper proposing significant regulatory changes (December 2006) and draft replacement legislation (May 2007),⁵⁴ and the HFEA has issued a new edition of its Code of Practice.⁵⁵ The new Code of Practice, which came into force on 5 July 2007, states that tissue typing is expected to be available only when the resulting child is to be used to treat “an existing child who is affected by a serious or life-threatening condition”.⁵⁶ The new draft legislation explicitly restricts tissue typing to such circumstances⁵⁷ and goes on to state that the regulatory authority must consider the

present or future availability of any alternative sources of tissue for treating the sibling and the likely long-term effect on the donor sibling.⁵⁸

In chapter 25, Søren Holm examines the so-called “non-identity problem”,⁵⁹ as seminally advanced and labelled by Derek Parfit.⁶⁰ Parfit famously noted that some reproductive decisions will result in the existence of *different* individuals and, thus, raise questions about whether any harm or wrong can be done to an individual whose very existence depends on that decision. (I have argued elsewhere that this argumentative strategy has particular purchase on rights-based moral theories.)⁶¹ Holm draws out the implications of two responses to the non-identity problem, which he identifies as the “standard analysis” and the “Harris analysis”. The standard analysis holds that a person has no legitimate complaint about an act that is a necessary condition of its existence, unless that person’s life is so bad that its life is not worth living (411). The Harris analysis is the view, attributed to John Harris, that *X harms Y* when *X* is in a disabling or hurtful condition and *Y* is responsible for *X* being in that condition, and that the *wrong* of wrongful life actions is increasing avoidable suffering in the world (416). Holm seeks to challenge these views by constructing hypothetical scenarios with “highly counter intuitive” consequences (415), including demonstrating that some extreme actions would be judged legitimate by both accounts (417). The persuasive import of such an argumentative strategy is limited to those moral theorists adhering to the particular intuitions in play.

Chapters 26–30

Chapters 26 to 30 address end of life decisions. In the first of these chapters, Loane Skene examines requests for life-prolonging treatment in the light of the *Burke* case,⁶² offering support for the decision of the Court of Appeal over that of Munby J at first instance.⁶³ She argues that the only possible duty to provide treatment arises from the “hospital-patient relationship and not from the patient’s wish for the treatment” (429). This theme is continued in the chapter written by Sheila McLean, the editor of this collection.⁶⁴ McLean argues that *Burke* further entrenched in law the notion that artificial nutrition and hydration (ANH) is medical treatment, as had been recognised in *Bland*.⁶⁵ While accepting that no court lower than the House of Lords could now hold otherwise, McLean laments this characterisation of ANH. She argues that a decoupling of ANH from medical treatment might have some (though not significant) resource implications, but “failure to do so has a cost in terms of humanity” (446), because ANH is inappropriately being treated in the same way as activities that “indubitably *are* medical treatments” (444). Classifying ANH as basic care, and thereby not medical treatment, would seem to impose a duty on doctors to administer ANH to any patient whose life could be sustained by it and place public policy limitations on the ability of any patient to refuse it.⁶⁶ Thus, such a response would also have consequences beyond those that are purely resource-focused. Imagine, for example, that Leslie Burke had wanted to refuse ANH.

In chapter 28, Tom Campbell claims that the notion of “euthanasia as a human right” needs to be re-characterised to avoid underemphasising “humanitarian considerations”.⁶⁷ This is followed by Len Doyal’s engaging chapter arguing for the legalisation of non-voluntary and voluntary euthanasia as a means of rendering English law internally coherent and compliant with societal expectations.⁶⁸ Doyal’s argument is imaginatively conducted by way of a hypothetical debate among

clinicians arguing over the approach advanced in Mason's co-authored book *Law and Medical Ethics*. Doyal rejects the book's reliance on the empirical slippery slope argument to support the case against legalisation—we have already seen that in the rejection of this argument Doyal is supported by Mason's current co-author of *Law and Medical Ethics*.

John Keown, in chapter 30, presents an impassioned defence of Recommendation 1418 passed by the Parliamentary Assembly of the Council of Europe in 1999 and opposing the legislation of euthanasia.⁶⁹ As readers have come to expect from Keown's work, his chapter makes many powerful logical points alongside claims that rest on particular moral premises.⁷⁰ Consider Keown's claim that

even if there *were* a serious discrepancy between the law and practice of voluntary euthanasia it would not follow that the gap should be narrowed by relaxing the law. Many criminal laws are regularly broken. Some prohibitions, such as the law against possessing hard drugs, are frequently breached without detection but it does not follow that the law should therefore be relaxed to accommodate those who snort cocaine. (483)

Since a serious discrepancy between a prohibition and the occurrence of the prohibited activity could justify removal of that prohibition *if* the justification for it were *purely instrumental*, Keown's claim requires further moral premises. He does go on to hint at these by advancing the view that euthanasia is *intrinsically* wrong, so that to criminalise "the decision to be intentionally killed, or to be helped to commit suicide...does not deny the patient's dignity but affirms it" (488). This conception of dignity holds that an individual can violate his or her own dignity, irrespective of utility considerations or the voluntary choice of that individual. As Beyleveld and Brownsword point out, such a conception of dignity (which they label "dignity as constraint") is opposed by another internally coherent conception (which they label "dignity as empowerment").⁷¹ It follows that it is not sufficient for Keown to merely assert his conception of dignity.

Chapters 31–37

It is much more difficult to find a single unifying theme for chapters 31 to 37. Chapter 31—written by Denise Avard, Linda Kharaboyan, and Bartha Knoppers—insightfully analyses the socio-ethical implications of newborn screening for sickle cell disease (SCD).⁷² They raise three main socio-ethical concerns: the difficulties presented by the identification of carriers, whether neonatal screening should be universal or selective, and the potential of consumer groups. We are told, for example, that despite early diagnosis and treatment being capable of significantly improving life expectancy and quality of life, most jurisdictions risk failing to identify all suffers by adopting selective neonatal screening programmes.⁷³

In Chapter 32, Mark Henaghan considers the regulation of genetic medicine in New Zealand.⁷⁴ Henaghan reveals, for example, that the regulatory policy towards HLA tissue-typing requires the affected child to have a hereditary gene disorder, like the much criticised previous policy of the UK's Human Fertilisation and Embryology Authority.⁷⁵ The overall regulatory framework, however, remains "piecemeal" and lacks "any clear unitary message" (526).

Roger Brownsword critically analyses attempts to invoke the harm principle as a regulative standard for pluralistic communities, using human cloning as the test case.⁷⁶ He sketches a particular kind of pluralism, a three-way disagreement on fundamental values with utilitarian, human rights, and dignitarian thinking occupying different corners of a “bioethical triangle”. Such pluralism, he argues, undermines the notion that a neutral regulative standard can be found in the idea that “we should do no harm to others (*primum no nocere*)” (528). The problem is that the harm principle is not neutral: “its regulative application turns on how the notion of ‘harm’ and the category of ‘others’ are interpreted; and these key ideas only take on a specific meaning once they are interpreted through the lens of a particular angle of the bioethical triangle” (537). The harm principle, thus, merely restates the challenge of pluralism. The harm principle cannot, as Montgomery has it in chapter one, provide an alternative to the imposition of a particular moral position; its content must derive from a particular moral position.

Marie Fox, in chapter 34, argues that healthcare law and healthcare lawyers disregard the harm caused to animals by new biotechnologies.⁷⁷ This is followed by Kenneth Norrie’s chapter on the unrelated issue of the regulatory response to gender and those who seek to change from one to the other.⁷⁸ He argues that while the inadequacies of one decision of the House of Lords⁷⁹ made the enactment of the Gender Recognition Act 2004 inevitable, a proper application of the reasoning of a later decision⁸⁰ limits its effect to marriage and, perhaps, re-registration of birth certificates.

The last two chapters examine the impact of recent scandals, reforms, and patient claims on doctors and the healthcare system. Christopher Newdick analyses the difficulties presented by limited healthcare resources and growing patient demands.⁸¹ Vivienne Harpwood enumerates and examines the impact of patient demands on doctors.⁸² Together these chapters helpfully seek to redress the imbalance created by focus upon the rights and demands of individual patients abstracted from their wider context.

III. Conclusion

This article is no more than an invitation to the festschrift’s diverse collection of topics and themes, the sheer breadth of which is an appropriate tribute to the work of Ken Mason.⁸³ While there are admittedly one or two pebbles filling what I am tempted to dismiss as much needed gaps, this book is packed with real gems and should therefore be given space on the shelves of all serious medical lawyers. As the title suggests, this book invites readers to consider the challenges of medical law and ethics. One of the most pressing of these challenges is the existence of irreconcilable moral views within pluralist communities. Even where there is apparently little variance of views on regulatory policy or outcome, there are often deep divisions on the underlying ethical principles, their weight, or justificatory support. In the face of alternative, firmly held and internally consistent intuitions, moral intuitionism is simply impotent, no matter how considered those intuitions or how carefully they are placed in reflective equilibrium.⁸⁴ While many of the book’s authors are nonetheless wedded to positions within moral intuitionism,⁸⁵ there are nods in the direction of moral foundationalism.⁸⁶ Overall, this book serves as an excellent overview of many important issues in medical law.

* *Editorial note:* Unlike articles, books reviews in this Journal are not anonymously reviewed. An exception has been made for this review article, as it is written by one of the editors and the book itself was edited by the Journal's book review editor. The author would therefore like to thank the reviewer.

- ¹ S. A. M. McLean, "Ken Mason – An Appreciation" (2005) 7(2) *Medical Law International* 169.
- ² While neighbouring chapters often share a linking theme, the chapters with similar foci are not consistently placed together. The chapters focussing medical research, for example, are chapters 6, 10, 11, 13, and 14.
- ³ J. Montgomery, "The Legitimacy of Medical Law", in S. A. M. Mclean (ed) *First Do No Harm* (Aldershot: Ashgate, 2006), 1.
- ⁴ See, e.g., S. D. Pattinson, *Influencing Traits Before Birth* (Aldershot: Ashgate, 2002) and *Medical Law and Ethics* (London: Sweet and Maxwell, 2006), ch 16.
- ⁵ R. Downie, "Cases and Casuistry", in McLean, *op cit* n 3, 17.
- ⁶ K. Boyd, "Medical Ethics: Hippocratic and Democratic Ideals", in McLean, *op cit* n 3, 29.
- ⁷ I. Frecklelton, "Contemporary Challenges in the Regulation of Health Practitioners", in McLean, *op cit* n 3, 39.
- ⁸ L. O. Gostin, "The International Health Regulations: A New Paradigm for Global Health Governance" in McLean, *op cit* n 3, 59.
- ⁹ Now in its seventh edition: J. K. Mason and G. T. Laurie, *Mason & McCall Smith's Law and Medical Ethics* (Oxford: Oxford University Press, 2006).
- ¹⁰ D. Chalmers, "International Medical Research Regulation: From Ethics to Law", in McLean, *op cit* n 3, 81.
- ¹¹ G. Magill, "Ethical and Policy Issues Related to Medical Error and Patient Safety", in McLean, *op cit* n 3, 101.
- ¹² See further Pattinson, *Medical Law and Ethics*, *op cit* n 4, ch 2.
- ¹³ V. English, R. Mussell, J. Sheather, and A. Sommerville, "Autonomy and its Limits: What Place for the Public Good?", in McLean, *op cit* n 3, 117.
- ¹⁴ G. Laurie, "The Autonomy of Others: Reflections on the Rise and Rise of Patient Choice in Contemporary Medical Law", in McLean, *op cit* n 3, 131.
- ¹⁵ [1981] 1 WLR 1421; [1986] AC 112; [1997] 2 FCR 541; [1998] AC 245; and (1992) 12 BMLR 38; respectively.
- ¹⁶ See further Pattinson, *Medical Law and Ethics*, *op cit* n 4, ch 16.
- ¹⁷ D. Beyleveld, "Conceptualising Privacy in Relation to Medical Research Values", in McLean, *op cit* n 3, 151.
- ¹⁸ See D. Beyleveld and S.D. Pattinson, "Moral Interests, Privacy and Medical Research", forthcoming in M. Bolan (ed) *International Public Health Policy and Ethics* (2007) (in press).
- ¹⁹ P. R. Ferguson, "Human 'Guinea Pigs': Why Patients Participate in Clinical Trials", in McLean, *op cit* n 3, 165.
- ²⁰ M. Brazier, "Human(s) (as) Medicine(s)", in McLean, *op cit* n 3, 187.
- ²¹ A. V. Campbell, "The Ethical Challenges of Biobanks: Safeguarding Altruism and Trust", in McLean, *op cit* n 3, 203.
- ²² T. Caulfield, "Biobanks and Blanket Consent: The Proper Place of the Public Good and Public Perception Rationales." (2007) *King's College Law Journal* (forthcoming).
- ²³ T. Takala, "Setting A Dangerous Precedent? Ethical Issues In Human Genetic Database Research" (2007) 9(2) *Medical Law International* 105, 127.
- ²⁴ Medicines for Human Use (Clinical Trials) Regulations 2004/1031, which implement Directive 2001/20/EC.
- ²⁵ J. McHale, "Law Reform, Clinical Research and Adults without Mental Capacity—Much Needed Clarification for a Recipe for Further Uncertainty?", in McLean, *op cit* n 3, 215.
- ²⁶ See D. Beyleveld and S. D. Pattinson, "Medical Research into Emergency Treatment: 'Regulatory Tensions in England and Wales.'" 5 (2006) *Web Journal of Current Legal Issues*, esp. the postscript on the Medicines for Human Use (Clinical Trials) Amendment (No. 2) Regulations 2006/2984.
- ²⁷ J. Devereux, "Continuing Conundrums in Competency", in McLean, *op cit* n 3, 235.
- ²⁸ *R v Clarence* (1888) 22 QBD 23; overruled by the Court of Appeal in *R v Dica* [2004] EWCA

Crim 1103, [2004] QB 1257.

See the discussion in Pattinson, *Medical Law and Ethics*, *op cit* n 4, ch 5, esp. 135–136.

Re MB [1997] 2 FLR 426, 437 (Butler-Sloss LJ).

R (Burke v GMC) [2004] EWHC 1879, para. 42 (my emphasis).

[2004] UKHL 41, [2005] 1 AC 134; D. Meyers, “Chester v Afshar: Sayonara, Sub Silentio, Sidaway?”, in McLean, *op cit* n 3, 255.

[1999] PIQR 53.

[1985] AC 871.

Cf. Pattinson, *Medical Law and Ethics*, *op cit* n 4, 110–113, esp. 111–112; E. Jackson, “‘Informed Consent’ to Medical Treatment and the Impotence of Tort”, in McLean, *op cit* n 3, 277–278; and A. R. Maclean, “The Doctrine of Informed Consent: Does it Exist and Has it Cross the Atlantic?” 24(3) *Legal Studies* 386.

See e.g. [2004] UKHL 41, 15

[1985] AC 871, 898 (Lord Bridge), 891 (Lord Diplock), and 902 (Lord Templeman): see further Pattinson, *Medical Law and Ethics*, *op cit* n 4, 113.

See e.g. [2004] UKHL 41, para. 5.

[1999] PIQR 53, 54.

See . [2004] UKHL 41, para. 39.

E. Jackson, “‘Informed Consent’ to Medical Treatment and the Impotence of Tort”, in McLean, *op cit* n 3, 273.

See further Pattinson, *Medical Law and Ethics*, *op cit* n 4, ch. 4, esp. 118.

J. Harris, “Mark Antony or Macbeth: Some Problems Concerning the Dead and the Incompetent when it Comes to Consent”, in McLean, *op cit* n 3, 287.

H. Teff, “No More ‘Shock Horror?’ The Declining Significance of ‘Sudden Shock’ and the ‘Horrificing Event’ in Psychiatric Injury Claims”, in McLean, *op cit* n 3, 303.

E. E. Sutherland, “Is There a Right Not to Procreate?”, in McLean, *op cit* n 3, 319.

B. Dickens, “Conscientious Objection: A Shield or a Sword?”, in McLean, *op cit* n 3, 337.

K. Petersen, “Classifying Abortion as a Health Matter: The Case for De-Criminalising Abortion Laws in Australia”, in McLean, *op cit* n 3, 352.

See S. Sheldon, “The Law of Abortion and the Politics of Medicalisation” in J. Bridgman and S. Millns (ed) *Law and Body Politics: Regulating the Female Body* (Aldershot: Dartmouth), 105 and S. Sheldon, *Beyond Control* (London: Pluto, 1997).

Sheldon, “The Law of Abortion and the Politics of Medicalisation”, *ibid*, 119 and 120.

P. Beem and D. Morgan, “What’s Love Got to do With it? Regulating Reproductive Technologies and Second Hand Emotions”, in McLean, *op cit* n 3, 369.

M. Freeman, “Saviour Siblings”, in McLean, *op cit* n 3, 389.

R (on the application of Josephine Quintavalle) v Human Fertilisation and Embryology Authority [2005] UKHL 28; [2005] 2 AC 561; House of Lords; *affirming* [2003] EWCA Civ 667; [2004] QB 168; CA (Civ Div).

Cf. HFEA, “HFEA agrees to extend policy on tissue typing”, press release, 21 July 2004 and HFEA, “New Guidance on Preimplantation Tissue Typing”, CH(04)05, 4 August 2004 (<http://www.hfea.gov.uk/en/599.html>).

Department of Health, *Review of the Human Fertilisation and Embryology Act: Proposals for Revised Legislation (including establishment of the Regulatory Authority for Tissue and Embryos)* (London: The Stationary Office, 2006); and Department of Health, *Human Tissue and Embryos (Draft) Bill: Draft Revised Legislation for Assisted Reproduction and Embryo Research (including Establishment of The Regulatory Authority for Tissue and Embryos)* (London: The Stationary Office); respectively.

HFEA, *Code of Practice* (7th edition) (London: HFEA).

Ibid., G.12.5.5.

The new Sch. 2, para 1ZA(1)(d).

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S. Holm, “Wrongful Life, the Welfare Principle and the Non-Identity Problem: Some Further Complications”, in McLean, *op cit* n 3, 407.

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See S. D. Pattinson, “Reproductive Cloning: Can Cloning Harm the Clone?” 10 *Medical Law Review* 295. See also Pattinson, *Medical Law and Ethics*, *op cit* n 4, 250–251, 296–298, and 325–326.

R (on application of Burke) v GMC [2005] EWCA Civ 1003; reversing [2004] EWCH 1879.

- ⁶³ L. Skene, “Life-Prolonging Treatment and Patients’ Legal Rights”, in McLean, *op cit* n 3, 421. Note that the pagination for this chapter in the book’s contents page is incorrect.
- ⁶⁴ S. McLean, “From Bland to Burke: The Law and Politics of Assisted Nutrition and Hydration”, in McLean, *op cit* n 3, 431. Note that the pagination for this chapter in the book’s contents page is incorrect.
- ⁶⁵ As accepted by the House of Lords in *Airedale NHS Trust Bland* [1993] AC 789, e.g. 858 (Lord Keith).
- ⁶⁶ See Pattinson, *Medical Law and Ethics*, *op cit* n 4, chs 4 (esp. 4.6.2) and 14 (esp. 14.3.1).
- ⁶⁷ T. Campbell, “Euthanasia as a Human Right”, in McLean, *op cit* n 3, 447.
- ⁶⁸ L. Doyal, “The Futility of Opposing the Legalisation of Non-Voluntary and Voluntary Euthanasia”, in McLean, *op cit* n 3, 461.
- ⁶⁹ J. Keown, “Defending the Council of Europe’s Opposition to Euthanasia”, in McLean, *op cit* n 3, 479.
- ⁷⁰ See further J. Keown, *Euthanasia, Ethics and Public Policy: An Argument Against Euthanasia* (Cambridge: Cambridge University Press, 2002) and the discussion in Pattinson, *Medical Law and Ethics*, esp 15.3.2.2. Analysis of Keown’s “logical” and “empirical” slippery slope arguments against legalisation can also be found in S. W. Smith, “Evidence for the Practical Slippery Slope in the Debate on Physician-Assisted Suicide and Euthanasia” (2005) 13 *Medical Law Review* 17 and S. W. Smith, “Fallacies of the Logical Slippery Slope in the Debate on Physician-Assisted Suicide and Euthanasia” (2005) 13 *Medical Law Review* 224.
- ⁷¹ D. Beylleveld and R. Brownsword, *Human Dignity in Bioethics and Biolaw* (Oxford: Oxford University Press, 2001), esp ch 1.
- ⁷² D. Avard, L. Kharaboyan, and B. Knoppers, in McLean, “Newborn Screening for Sickle Cell Disease: Socio-Ethical Implications”, *op cit* n 3, 495.
- ⁷³ We are repeatedly told that England and most American states have universal screening programmes: *ibid.*, 488, 499, and 504.
- ⁷⁴ M. Henaghan, “The ‘Do No Harm’ Principle and the Genetic Revolution in New Zealand”, in McLean, *op cit* n 3, 511.
- ⁷⁵ For criticisms of the UK policy see S. D. Pattinson “Designing Donors” in J. Gunning and S. Holm (eds) *Ethics, Law and Society* (Aldershot: Ashgate, 2005), 251 (originally published in July 2003 at <http://www.ccels.cardiff.ac.uk/issue.html>) and S. Sheldon and S. Wilkinson “Hashmi and Whitaker: An Unjustifiable and Misguided Distinction?” (2004) 12 *Medical Law Review* 137.
- ⁷⁶ R. Brownsword, “Cloning, Zoning and the Harm Principle”, in McLean, *op cit* n 3, 527.
- ⁷⁷ M. Fox, “Exposing Harm: The Erasure of Animal Bodies in Health Care Law” in McLean, *op cit* n 3, 543.
- ⁷⁸ K. Norrie, “Is the Gender Recognition Act 2004 as Important as it Seems?”, in McLean, *op cit* n 3, 561.
- ⁷⁹ *Bellinger v Bellinger* [2003] UKHL 21.
- ⁸⁰ *A v Chief Constable of West Yorkshire Police* [2004] UKHL 21.
- ⁸¹ C. Newdick, “The Positive Side of Health Care Rights”, in McLean, *op cit* n 3, 573.
- ⁸² V. Harpwood, “In Defence of Doctors”, in McLean, *op cit* n 3, 587.
- ⁸³ This latter view is shared by S. McCall Smith, “Ken—An Appreciation”, in McLean, *op cit* n 3, xv, xv.
- ⁸⁴ See further Pattinson, *Medical Law and Ethics*, *op cit* n 4, ch. 16.
- ⁸⁵ E.g. Montgomery, Downie, Brazier, Harris, and Holm.
- ⁸⁶ E.g. Beylleveld and Brownsword.